

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN669HOS</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/30/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>RENOWN REGIONAL MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1155 MILL STREET RENO, NV 89502</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Surveyor: 23119 This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 9/30/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.</p> <p>Complaint #NV00023152 was unsubstantiated with no deficiencies cited. Complaint #NV00022902 was partially substantiated with deficiencies cited. (See Tag S 115)</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	S 000		
S 115 SS=D	<p>NAC 449.325 Infections and Communicable Diseases</p> <p>1. A hospital shall: (a) Provide a sanitary environment to avoid sources and transmission of infections and communicable diseases This Regulation is not met as evidenced by:</p>	S 115		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 115	Continued From page 1  Surveyor: 23119 Based on interview the facility failed to provide tissues or a basin to contain soiled tissues from a nose bleed for 1 of 5 patients (#2).  Severity 2    Scope 1	S 115			

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